sensus of opinion would indicate that the possibility of organic lesions, such as pituitary tumors, should be ruled out following 6 to 12 months of amenorrhea. Attempts at inducing ovulation using clomiphene or Pergonal® should be made only in patients desiring conception. These agents are not without potential complications and should be employed only after adequate studies have proven normal thyroid and adrenal function and there is some indication of normal estrogen and total pituitary gonadotropin output.

Careful selection of patients for steroid suppression of ovulation is the key to minimizing the frequency of amenorrhea following discontinuance of steroid oral contraceptives.

FREDERICK W. HANSON, M.D.

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Guidelines in Estrogen Therapy

Estrogen replacement therapy is indicated in deficiency states occurring after the menopause for relief of specific symptoms such as "hot flashes" or genital atrophy, unless there are contraindications such as breast malignancy, endometrial cancer or thromboembolic disease. Prophylactic administration of estrogens to decrease the risk of the postmenopausal occurrence of osteoporosis and coronary artery disease may be useful, but this has not been conclusively demonstrated. Balanced against any possible short or long-term benefits of estrogen are major hazards which include vaginal cancer in the female offspring of mothers receiving the hormone during pregnancy, and the increased risk of thromboembolism and myocardial infarction. Fortunately, the dose of hormone associated with complications (5 mg of conjugated estrogens, 0.1 mg of ethinyl estradiol) is generally higher than necessary. A reasonable guide is to use the lowest effective dose (0.3 to 0.625 mg conjugated estrogens) under surveillance for any possible complications. A requirement for high dosage should be viewed with suspicion and all abnormal uterine bleeding checked by a Papanicolaou test and biopsy and by a dilation and curettage if bleeding persists after the hormone is discontinued.

KENNETH J. RYAN, M.D.

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The Case of the Vanishing Disease

To correctly treat erythroblastosis, a careful previous obstetrical history must be taken. If there were problems in the past, this will red light the possible future problems. Obtaining ABO factor, Rh, and antibody screening laboratory work is next in importance. If the patient is Rh-negative and primipara, is negative to antibody screening, and has no history of blood transfusions, a repeat antibody screen should be performed at approximately 37 weeks. If the patient has had previous obstetrical history of Rh problems or abortions, or has received blood transfusions, an antibody screen and titer should be repeated at approximately 24 weeks. If the titer has increased by a two-tube rise, then amniocentesis must be performed at that time. The optical density of the amniotic fluid is then determined and the procedure repeated every ten days to two weeks and the result recorded on a Liley grid. If the optical density level is in the non-affected range and remains there, the patient can be allowed to go to term. If on the other hand it is in the mid-zone, it must be followed carefully to determine the future course. If it does not enter the third zone until after 34 weeks but then rises to dangerous levels, delivery can be effected vaginally by induction of labor. However, if it enters the severe zone before 34 weeks' gestation, an intrauterine blood transfusion is necessary. Approximately 50 percent salvage rate has resulted from this procedure. If an Rh-